280031

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR — REG. NO. 26916

1. DECEASED NAME (TYPE OR PRINT): First: Luther; Middle: L.; Last: Dix

2a. DATE OF DEATH: KNOWN [X] ESTIMATED [ ] Month Day Year: 9/23/85 — 2b. HOUR: 5:00 P.M.

3. SEX: Male — 4. RACE: Black — 5. DATE OF BIRTH Month Day Year: 5/10/1899 — 6. AGE (IN YEARS LAST BIRTHDAY): 86 YRS. — IF UNDER 1 YR. Months Days — IF UNDER 24 HRS. Hours Min

2c. DATE PRONOUNCED DEAD Month Day Year: 9/23/85 — 2d. HOUR: 5:25 P.M.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Pocomoke, Md. — 7b. CITIZEN OF WHAT COUNTRY?: USA — 8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]

9. BALTIMORE CITY OR COUNTY OF DEATH: Worcester MD.

10. CITY OR TOWN OF DEATH: Pocomoke, Md. — 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Rural - Pocomoke

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Retired — 12b. KIND OF BUSINESS OR INDUSTRY: Railroad

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Md. — 13b. COUNTY: Worcester — 13c. CITY OR TOWN: Pocomoke City — 13d. INSIDE CITY LIMITS? YES [ ] NO [X] — 13e. STREET ADDRESS: P.O. Box 403 Pocomoke, Md. 21851

14. FATHER'S NAME: First: Addison; Middle: ; Last: Dix

15. MOTHER'S MAIDEN NAME: First: Clara; Middle: ; Last: Unk

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN): No — (IF YES, GIVE WAR OR DATES): —

16b. SOCIAL SECURITY NO.: 709-10-4654

17. INFORMANT: Luther Dix, Jr. — ADDRESS: 670 Riverside Dr. N.Y.C. 10031

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardiac Arrest
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (b): myocardial infarction
DUE TO, OR AS A CONSEQUENCE OF (c): ASCVD

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 a.

19a. DATE OF OPERATION — 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? — 20. AUTOPSY? YES [ ] NO [ ]

21a. EXTERNAL CAUSE WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH — 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 — 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ] — 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) — 21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that I took charge of the remains described above, held an Autopsy [ ], Inspection [ ], Inquiry [✓], and in my opinion death resulted from: Natural causes [✓], Accident [ ], Suicide [ ], Homicide [ ], Undetermined manner [ ].

ACTUAL SIGNATURE: Timothy E. Bamman — TITLE (SPECIFY): Deputy MEDICAL EXAMINER — DATE SIGNED: 9/24/85

EXAMINER'S NAME (TYPE OR PRINT): _____ ADDRESS: _____

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial — 23b. DATE: 9-27-85 — 23c. NAME OF CEMETERY OR CREMATORY: Trinity U.M. Cem. — 23d. LOCATION CITY OR TOWN: Pocomoke — COUNTY: Wor. — STATE: Md.

24. FUNERAL DIRECTOR (NAME) — ADDRESS: Samuel G. Savage New Church, Va. — 25a. DATE RECD. BY REGISTRAR: OCT 2 1985 — 25b. REGISTRAR'S SIGNATURE: Julia Davidson-Gordale

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGE 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM FM 25 BETA. PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/84 25M BP

DHMH - 17 (VR A15 ME (5))

275013

FOR 1 - STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 26917

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

**TO MEDICAL EXAMINER:** THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 72 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 1. RETAIN PAGE 5 FOR YOUR FILES.
**TO FUNERAL DIRECTOR:** PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| | | | | | | |
|---|---|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST / MIDDLE / LAST | Elmer | Avery | Downs | 2a. DATE OF DEATH KNOWN ☐ ESTIMATED ☑ MONTH DAY YEAR | 9/20/1985 | 2b. HOUR 4:A.M. |
| 3. SEX | Male | 4. RACE | W | 5. DATE OF BIRTH MONTH DAY YEAR | 10 14 07 | 6. AGE (IN YEARS LAST BIRTHDAY) | 77 YRS. |
| IF UNDER 1 YR. MONTHS / DAYS | | IF UNDER 24 HRS. HOURS / MIN | | 2c. DATE PRONOUNCED DEAD MONTH DAY YEAR | 9/20/1985 | 2d. HOUR 8:30 a.m. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | Virginia | 7b. CITIZEN OF WHAT COUNTRY? | U.S.A. | 8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ | | 9. BALTIMORE CITY OR COUNTY OF DEATH | Worcester MD. |
| 10. CITY OR TOWN OF DEATH | Newark | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | Rt 1, Box 38 | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | farmer | 12b. KIND OF BUSINESS OR INDUSTRY | farmer |

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS |
|---|---|---|---|---|
| Maryland | Worcester | Newark | YES ☒ NO ☐ | Rt 1, Box 38/21811 |

| 14. FATHER'S NAME FIRST / MIDDLE / LAST | 15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST |
|---|---|
| Joseph G. Downs | Elizabeth Butler |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS |
|---|---|---|
| No | 218-16-6843 | Lee Savage, Berlin Ambulance Service, Berlin, Maryland |

**MEDICAL CERTIFICATION**

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:

| | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| IMMEDIATE CAUSE (a) | Cardiac arrest | |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b) | leukemia | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | |

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |
|---|---|---|
| | | |

| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE |
|---|---|---|
| | | |

22a. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☑, and in my opinion death resulted from: Natural causes ☑, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐,

ACTUAL SIGNATURE Timothy E. Bamim M.D. TITLE (SPECIFY) Deputy MEDICAL EXAMINER DATE SIGNED 9/20/85

EXAMINER'S NAME (TYPE OR PRINT) _____ ADDRESS _____

| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN / COUNTY / STATE |
|---|---|---|---|
| Burial | 9/23/85 | Riverside Cemetery | Libertytown Wor MD |

| 24. FUNERAL DIRECTOR NAME / ADDRESS | 25a. DATE REC'D. BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| W. Kirk Burbage, 108 Wms. St., Berlin, MD | SEP 24 1985 | Julia Tingle Burbage |

07/84 25M BP_____ DHMH - 17 (VR A15 ME (5))

287045

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO. 85 26918

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST | MIDDLE | LAST | 2a. DATE OF DEATH MONTH DAY YEAR | 2b. HOUR | |
| LOUIS | | FISHER | 9/28/85 | 12:15 PM | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH MONTH DAY YEAR | 6. AGE (IN YEARS LAST BIRTHDAY) | IF UNDER 1 YEAR MONTHS / DAYS | IF UNDER 24 HRS. HOURS / MIN. |
| MALE | WHITE | 8/24/04 | 81 YRS. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒ | 9. BALTIMORE CITY OR COUNTY OF DEATH | | |
| MD | U.S. | | WORCESTER MD. | | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | 12b. KIND OF BUSINESS OR INDUSTRY | |
| BERLIN | BERLIN NURSING HOME | | MEATCUTTER | | |

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS / ZIP CODE |
|---|---|---|---|---|
| MD | WORCESTER | OCEAN CITY | YES ☒ NO ☐ | 109 N. FIRST STREET / 21842 |

| 14. FATHER'S NAME FIRST MIDDLE LAST | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST |
|---|---|
| UNKNOWN | UNKNOWN |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| NO | | 215-10-4619 | F. CERATO | BALTO, MD. |

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) ACUTE MI

DUE TO, OR AS A CONSEQUENCE OF (b) DVA.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

DUE TO, OR AS A CONSEQUENCE OF (c) AGING

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | YES ☐ NO ☐ | YES ☐ NO ☐ |

| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |
|---|---|---|
| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE |

22a. I certify that (I) (this hospital) attended the deceased from 2-21-84 to 9-28-85, that (I) (we) last saw the deceased alive on 9-27-85, 19__, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE DEGREE MD ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☒ STAFF PHYSICIAN ☐ 22c. DATE SIGNED

22d. PHYSICIAN'S NAME (TYPE OR PRINT) FEDERICO ARTHES, MD

22e. ADDRESS 3 BAY ST., BERLIN, MD 21811

| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN COUNTY STATE |
|---|---|---|---|
| BURIAL | 10-1-85 | SUNSET MP. | BERLIN WOR. MD |

| 24. FUNERAL DIRECTOR NAME ADDRESS | 25a. DATE REC'D. BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| ULRICK F.H. BERLIN MD. | OCT 7 [redacted] | Julia Tilden Rogers |

BP_____

DHMH - 16 60M 7/84
(VRA 15, 4)

275058

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

1- FOR STATE REGISTRAR

# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

85 26919 REG. NO.

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201

**TO MEDICAL EXAMINER:** THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM FH-[illegible]. RETAIN PAGE 5 FOR YOUR FILES.
**TO FUNERAL DIRECTOR:** PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST: PAUL | MIDDLE: ANTHONY | LAST: GRIFFIN | 2a. DATE OF DEATH KNOWN ☐ ESTIMATED ☑ MONTH DAY YEAR: 9-22-19 85 | 2b. HOUR: 3 AM |
| 3. SEX: MALE | 4. RACE: WHITE | 5. DATE OF BIRTH MONTH DAY YEAR: 6-22-20 | 6. AGE (IN YEARS LAST BIRTHDAY): 65 YRS. IF UNDER 1 YR. MONTHS DAYS; IF UNDER 24 HRS. HOURS MIN | 2c. DATE PRONOUNCED DEAD MONTH DAY YEAR: 9-22-1985 | 2d. HOUR: 5:15 AM |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): OKLAHOMA | 7b. CITIZEN OF WHAT COUNTRY?: USA | 8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ | 9. BALTIMORE CITY OR COUNTY OF DEATH: WORCESTER MD. | | |
| 10. CITY OR TOWN OF DEATH: BERLIN, 21811 | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY GIVE STREET ADDRESS): 3 KAFT COURT | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): U.S. ARMY | 12b. KIND OF BUSINESS OR INDUSTRY: DEFENSE | | |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: OHIO | 13b. COUNTY: | 13c. CITY OR TOWN: AKRON | 13d. INSIDE CITY LIMITS? YES ☒ NO ☐ | 13e. STREET ADDRESS: 341 CATALOBA DRIVE | |
| 14. FATHER'S NAME FIRST: EDGAR | MIDDLE: F. | LAST: GRIFFIN | 15. MOTHER'S MAIDEN NAME FIRST: AUDENE | MIDDLE: SHATTUCK | LAST: |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): YES | (IF YES GIVE WAR OR DATES): WWII-1963 | 16b. SOCIAL SECURITY NO.: 174-14-7284 | 17. INFORMANT: LOIS J. GRIFFIN | ADDRESS: AKRON, O. | |

**MEDICAL CERTIFICATION**

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): cardiac Arrest
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (b): myocardial Infarction
DUE TO, OR AS A CONSEQUENCE OF (c): A.S.C.V.D.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).

| | | |
|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | 20. AUTOPSY? YES ☐ NO ☐ |
| 21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |
| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE |

22a. I certify that I took charge of the remains described above, held on Autopsy ☐, Inspection ☐, Inquiry ☑, and in my opinion death resulted from: Natural causes ☑, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐.

ACTUAL SIGNATURE: Timothy E. Baumann M.D. TITLE (SPECIFY): Deputy MEDICAL EXAMINER DATE SIGNED: 9/23/85

EXAMINER'S NAME (TYPE OR PRINT): Tim BAUMANN ADDRESS: 16th & Philadelphia Ocean City, MD 21842

| | | | | |
|---|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY): BURIAL | 23b. DATE: 9/25/85 | 23c. NAME OF CEMETERY OR CREMATORY: QUANTICO NAT'L | 23d. LOCATION CITY OR TOWN: TRIANGLE | COUNTY: P.W. | STATE: VA. |
| 24. FUNERAL DIRECTOR NAME: ULRICH F.H. | ADDRESS: BERLIN, MD. | 25a. DATE REC'D. BY REGISTRAR: SEP 30 1985 | 25b. REGISTRAR'S SIGNATURE: [illegible] | | |

BP

DHMH - 17
(VR A15 ME(5))
30M 7/73

269062

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO. 85 26920

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

(IMPORTANT) If Item 21 is marked yes, Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST | MIDDLE | LAST | 2a. DATE OF DEATH MONTH | DAY | YEAR | 2b. HOUR |
| SALLY | G. | LLOYD | 9 | 15 | 85 | 4:30 PM |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH MONTH DAY YEAR | 6. AGE (IN YEARS LAST BIRTHDAY) | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. |
| FEMALE | WHITE | 7 24 89 | 96 YRS. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ | 9. BALTIMORE CITY OR COUNTY OF DEATH | | |
| MARYLAND | USA | | WORCESTER MD. | | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | 12b. KIND OF BUSINESS OR INDUSTRY |
| BERLIN | BERLIN NURSING HOME | HOUSEWIFE | OWN HOME |

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS / ZIP CODE |
|---|---|---|---|---|
| MD | WICOMICO | HEBRON | YES ☒ NO ☐ | 201 WALNUT STREET 21830 |

| 14. FATHER'S NAME FIRST | MIDDLE | LAST | 15. MOTHER'S MAIDEN NAME FIRST | MIDDLE | LAST |
|---|---|---|---|---|---|
| GREENSBURY | | Gillis | MARY | ELIZABETH | CALLOWAY |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| NO | - | 218 05 8976 | Edward Hastings | 65 Westside Dr. Rehoboth Beach, Del 19971 |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

| | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| IMMEDIATE CAUSE (a) | Acute MI. | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b) | Chronic Renal Failure. | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | Severe Abuse PSVD. | |

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☐ | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐ |
|---|---|---|---|
| | | | |

| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |
|---|---|---|
| | | |

| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE |
|---|---|---|
| | | |

22a. I certify that (I) (this hospital) attended the deceased from Jan 82, 19__, to Sep, 19 85, that (I) (we) last saw the deceased alive on Sep 11, 19 85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | | 22c. DATE SIGNED |
|---|---|---|---|
| Federico J. Arthes | M.D | ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☒ STAFF PHYSICIAN ☐ | 9-16-85 |

| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | 22e. ADDRESS |
|---|---|
| FEDERICO ARTHES, MD. | 3 BAY STREET, BERLIN, MD. 21811 |

| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN / COUNTY / STATE |
|---|---|---|---|
| Burial | 9-17-85 | Mardela Mem. Cem | Mardela Springs Wicomico MD |

| 24. FUNERAL DIRECTOR NAME | ADDRESS | 25a. DATE REC'D. BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|---|
| Baker and Bounds | Salisbury, MD | SEP 18 1985 | |

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

275159

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

85 26921
REG. NO.

| 1. DECEASED NAME (TYPE OR PRINT) FIRST | MIDDLE | LAST | 2a. DATE OF DEATH MONTH DAY YEAR | 2b. HOUR |
|---|---|---|---|---|
| JoAnn | Tracy | Morton | 9-21-85 | 7:50 p.m. |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH MONTH DAY YEAR | 6. AGE (IN YEARS LAST BIRTHDAY) | IF UNDER 1 YEAR MONTHS DAYS | IF UNDER 24 HRS. HOURS MIN. |
|---|---|---|---|---|---|
| Female | Cauc. | May 14, 1925 | 60 YRS. | | |

| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED XX NEVER MARRIED WIDOWED DIVORCED | 9 BALTIMORE CITY OR COUNTY OF DEATH |
|---|---|---|---|
| West Virginia | U.S.A. | | Worcester MD. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| Ocean City | 13401 Wight Street, Ocean City | Secretary | School syste |

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS / ZIP CODE |
|---|---|---|---|---|
| Maryland | Worcester | Ocean City | YES X NO | 13401 Wight St. 21842 |

| 14. FATHER'S NAME FIRST | MIDDLE | LAST | 15. MOTHER'S MAIDEN NAME FIRST | MIDDLE | LAST |
|---|---|---|---|---|---|
| Mount | V. | Tracy | Delia | | Hammrick |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| No | | 235-34-0899 | Richard A. Morton | 13401 Wight St. Ocean City, Md. |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

| | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| IMMEDIATE CAUSE (a) | Carcinoma of the Lung | |
| DUE TO, OR AS A CONSEQUENCE OF (b) | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | |

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES NO | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES NO |
|---|---|---|---|
| | | | |

| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |
|---|---|---|
| | | |

| 21d. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE |
|---|---|---|
| | | |

22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to Sept. 21, 19 85, that ~~she~~ (we) last saw the deceased alive on Sept. 21 19 85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) ~~had visited~~ (did not) view the body after death.

| 22b. SIGNATURE DEGREE | ATTENDING PHYSICIAN / MEDICAL DIRECTOR / STAFF PHYSICIAN | 22c. DATE SIGNED |
|---|---|---|
| J. E. Martin, M.D. | ATTENDING PHYSICIAN X | 9/22/85 |

| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | 22e. ADDRESS |
|---|---|
| James E. Martin, M.D. | 1300 S. Division St., Salisbury, MD. |

| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN COUNTY STATE |
|---|---|---|---|
| Cremation | 9-22-85 | Cape Henlopen | Lewes Sussex DE. |

| 24. FUNERAL DIRECTOR NAME | ADDRESS | 25a. DATE REC'D BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|---|
| W. Kirk Burbage | 108 Williams, Berlin, Md. | SEP 25 1985 | Julia Anderson Rogers |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon sheet. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked yes, item 18 should show injury, or other traumatic event, the medical history of which is the cause of death.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP_____

DHMH - 16 50M 4/83
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

REG. NO. 85 26922

1. DECEASED NAME (TYPE OR PRINT): Essie (FIRST) Marie (MIDDLE) Purcell (LAST)

2a. DATE OF DEATH: 09 (MONTH) 08 (DAY) 1985 (YEAR) | 2b. HOUR: 5:15p M

3. SEX: Female | 4. RACE: Caucasian | 5. DATE OF BIRTH: 09 (MONTH) 2 ~~07~~ (DAY) 1910 ~~1911~~ (YEAR) | 6. AGE (IN YEARS LAST BIRTHDAY): ~~74~~ 75 YRS. | IF UNDER 1 YEAR: MONTHS DAYS | IF UNDER 24 HRS.: HOURS MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland | 7b. CITIZEN OF WHAT COUNTRY?: U.S. | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒ | 9. BALTIMORE CITY OR COUNTY OF DEATH: Worcester MD.

10. CITY OR TOWN OF DEATH: Pocomoke City | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Hartley Hall Nursing Home | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): retired Factory Worker | 12b. KIND OF BUSINESS OR INDUSTRY

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Maryland | 13b. COUNTY: Worcester | 13c. CITY OR TOWN: Pocomoke City | 13d. INSIDE CITY LIMITS? YES ☒ NO ☐ | 13e. STREET ADDRESS / ZIP CODE: Clarke Ave. 21851

14. FATHER'S NAME (FIRST MIDDLE LAST): Cleveland Mister

15. MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST): ~~Marie~~ Manie Dize

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): no (IF YES, GIVE WAR OR DATES)

16b. SOCIAL SECURITY NO.: 215-05-8898

17. INFORMANT: Mildred F. Purcell | ADDRESS: P.O. Box 113 Kensale, Va. 22488

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Natural Causes
DUE TO, OR AS A CONSEQUENCE OF (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (c):
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a:

19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☐ | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from March 13, 19 85, to September 8 19 85, that (I) (we) last saw the deceased alive on 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Paul R Fleury | DEGREE: ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ | 22c. DATE SIGNED

22d. PHYSICIAN'S NAME (TYPE OR PRINT): PAUL R FLEURY | 22e. ADDRESS: 305 10th St., Pocomoke City, Md. 21851

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial | 23b. DATE: 9/10/85 | 23c. NAME OF CEMETERY OR CREMATORY: Salem Meth. Cem. | 23d. LOCATION CITY OR TOWN: Pocomoke COUNTY: Worcester STATE: Md.

24. FUNERAL DIRECTOR NAME: Scott S. Melson | ADDRESS: Pocomoke City, Md. | 25a. DATE REC'D. BY REGISTRAR: SEP 12 1985 | 25b. REGISTRAR'S SIGNATURE

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 3 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Page 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of and

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

261028

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1- FOR STATE REGISTRAR

85 26923
REG. NO.

1. DECEASED NAME (TYPE OR PRINT): FIRST Harvey; MIDDLE Edgar; LAST Reedy, Jr.

2a. DATE OF DEATH: KNOWN ☐ ESTIMATED ☐ MONTH 09 DAY 08 YEAR 1985

2b. HOUR M

3. SEX: Male

4. RACE: Negro

5. DATE OF BIRTH: MONTH 04 DAY 28 YEAR 67

6. AGE (IN YEARS LAST BIRTHDAY): 18 YRS. IF UNDER 1 YR. MONTHS DAYS; IF UNDER 24 HRS. HOURS MIN.

2c. DATE PRONOUNCED DEAD: MONTH 09 DAY 08 YEAR 1985

2d. HOUR M

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Washington, DC U.S.A.

7b. CITIZEN OF WHAT COUNTRY?

8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH: Worcester MD.

10. CITY OR TOWN OF DEATH: Ocean City

11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Caroline Street

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): student

12b. KIND OF BUSINESS OR INDUSTRY: None

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Maryland

13b. COUNTY: Prince Geroge

13c. CITY OR TOWN: Seat Pleasantx

13d. INSIDE CITY LIMITS? YES ☐ NO ☐

13e. STREET ADDRESS: 221 Yolanda Avenue 20743

14. FATHER'S NAME: FIRST Harvey; MIDDLE Edgar; LAST Reedy, Sr.

15. MOTHER'S MAIDEN NAME: FIRST Sally; MIDDLE; LAST Penn

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN): No

IF YES, GIVE WAR OR DATES:

16b. SOCIAL SECURITY NO.: 216-02-7809

17. INFORMANT ADDRESS: Federico G. Arthes, M.D. 3 Bay St., Berlin, MD

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:

9108

IMMEDIATE CAUSE (a): DROWN - IN - OCEAN.

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b): —

DUE TO, OR AS A CONSEQUENCE OF (c): —

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a): None

19a. DATE OF OPERATION: —

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?: —

20. AUTOPSY? YES ☐ NO ☒

21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH

21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2): —

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)

21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐.

ACTUAL SIGNATURE: Federico G. Arthes TITLE (SPECIFY): M.D. Deputy MEDICAL EXAMINER DATE SIGNED: 9-4-85

EXAMINER'S NAME (TYPE OR PRINT): F. G. Arthes M.D. ADDRESS: 3 Bay St Berlin

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial

23b. DATE: 9/13/85

23c. NAME OF CEMETERY OR CREMATORY: Harmony Cemetery

23d. LOCATION CITY OR TOWN: Seat Pleasant P.G. COUNTY 17 STATE MD

24. FUNERAL DIRECTOR NAME: Dudley, S Fun Home ADDRESS: 1425 Maryland Ave DC

25a. DATE REC'D. BY REGISTRAR: SEP 16 1985

25b. REGISTRAR'S SIGNATURE

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM FM 3. RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84 25M BP

DHMH - 17 (VR A15 ME (5))

254015

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1- FOR STATE REGISTRAR

85 26924 REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST | MIDDLE | LAST | 2a. DATE OF DEATH KNOWN ☐ ESTIMATED ☐ MONTH DAY YEAR | 2b. HOUR |
| Scott | Dreyer | Taylor | 19 | M |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH MONTH DAY YEAR | 6. AGE (IN YEARS LAST BIRTHDAY) | IF UNDER 1 YR. MONTHS / DAYS | IF UNDER 24 HRS. HOURS / MIN. | 2c. DATE PRONOUNCED DEAD MONTH DAY YEAR | 2d. HOUR |
| Male | White | 4/11/64 | 21 YRS. | | | AUG 30 1985 | 11:30 M |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐ | 9. BALTIMORE CITY OR COUNTY OF DEATH | |
| Maryland | U.S. | | Worcester MD. | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | 12b. KIND OF BUSINESS OR INDUSTRY |
| Snow Hill | John Franklin Jones Lumber Co | Laborer | |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | |
| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? YES ☐ NO ☒ | 13e. STREET ADDRESS | |
| Maryland | Somerset | Princess Anne | | Route 3 | 21853 |
| 14. FATHER'S NAME FIRST | MIDDLE | LAST | 15. MOTHER'S MAIDEN NAME FIRST | MIDDLE | LAST |
| Ernest | | Taylor | Wilma | | Dreyer |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) | (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
| no | | | Mrs. Ernest Taylor | Rt. 3 Md. Princess Anne |

**MEDICAL CERTIFICATION**

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:

9198 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

(a) IMMEDIATE CAUSE: Multiple Severe Wounds-

DUE TO, OR AS A CONSEQUENCE OF

(b) cl dismember of Body +

DUE TO, OR AS A CONSEQUENCE OF

(c) Lost of all abdomd Organs-

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).

| | | |
|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | 20. AUTOPSY? YES ☐ NO ☒ |
| | | |

| | | | |
|---|---|---|---|
| 21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | |
| | 1130 P.M. Aug 30 1985 | Pt went through a Debarker- | |
| 21d. INJURY OCCURRED WHILE AT WORK ☒ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE | |
| | Lumbers Mill- | Jones Lumber Co- 632-0373 C301- | |

22a. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☒ Suicide ☐, Homicide ☐, Undetermined manner ☐,

ACTUAL SIGNATURE Fernand L. Amos M.D. TITLE (SPECIFY) M.D. MEDICAL EXAMINER DATE SIGNED Aug 31-85

EXAMINER'S NAME (TYPE OR PRINT) F. G. Arthes - MD. ADDRESS 3 Bay St Berlin Md. 21811

| | | | | |
|---|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN / COUNTY / STATE | |
| Cremation | 8/31/85 | Salisbury Crematory | Salisbury, Wicomico Md. | |
| 24. FUNERAL DIRECTOR NAME | ADDRESS | 25a. DATE REC'D. BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE | |
| James L. Dennis | Princess Anne Md | SEP 05 1985 | Julia Davidson-Register | |

BP

DHMH - 17
(VR A15 ME (5))
20M 4/82

277019

1 - FOR STATE REGISTRAR

**STATE OF MARYLAND**
**DEPARTMENT OF HEALTH AND MENTAL HYGIENE**
**CERTIFICATE OF DEATH**

85 26925
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be filed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (Page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be informed.

BP_____

DHMH - 16 50M 4/83
(VRA 15, 4)

| | | | | |
|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) First: Hilda | Middle: Anne | Last: Topping | 2a. DATE OF DEATH Month: 09 Day: 24 Year: 85 | 2b. HOUR M |
| 3. SEX: Female | 4. RACE: Caucasian | 5. DATE OF BIRTH Month: 03 Day: 15 Year: 28 | 6. AGE (IN YEARS LAST BIRTHDAY): 56 YRS. | If under 1 year: Months / Days / Hours / Min. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland | 7b. CITIZEN OF WHAT COUNTRY?: U.S.A. | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ | 9. BALTIMORE CITY OR COUNTY OF DEATH: Worcester MD. | |
| 10. CITY OR TOWN OF DEATH: Ocean City | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Box 314 | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): housekeeping | 12b. KIND OF BUSINESS OR INDUSTRY: domestic |

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS / ZIP CODE |
|---|---|---|---|---|
| MD | Worcester | Ocean City | YES ☒ NO ☐ | Box 314 21842 |

| 14. FATHER'S NAME First / Middle / Last | 15. MOTHER'S MAIDEN NAME First / Middle / Last | 17. INFORMANT ADDRESS |
|---|---|---|
| Edward / / Spencer | Nancy / Ellen / Clark | Barbara J. Carpenter, Box 314, Ocean City, MD 21842 |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO. |
|---|---|---|
| No | | 231-30-1316 |

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

| | | Approximate interval between onset and death |
|---|---|---|
| IMMEDIATE CAUSE (a) | CARDIOPULMONARY ARREST | MINUTES |
| DUE TO, OR AS A CONSEQUENCE OF (b) | DIFFUSE ADENOCARCINOMA OF BREAST | WEEKS |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | |

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a
CORONARY ARTERY DISEASE

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| 8/21/85 | INTESTINAL OBSTRUCTION | YES ☐ NO ☐ | YES ☐ NO ☐ |

| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |
|---|---|---|
| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE |

22a. **I certify** that (I) (this hospital) attended the deceased from 9/27 19 83 to 9/12/85 or _____, that (I) (we) last saw the deceased alive on 8/21/85 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | 22c. DATE SIGNED |
|---|---|---|
| John A. Bartkovich MD | ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ | 9/25/85 |

| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | 22e. ADDRESS |
|---|---|
| JOHN A. BARTKOVICH | BOX BLUFF RD. SALIS. Md. 21801 |

| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN / COUNTY / STATE |
|---|---|---|---|
| Burial | 9/26/85 | Sunset Memorial Pk | Berlin Worcester MD |

| 24. FUNERAL DIRECTOR NAME / ADDRESS | 25a. DATE REC'D. BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| W. Kirk Burbage, 108 Wms St., Berlin, MD | SEP 30 1985 | Julia Davidson Randall |